TIMMINS AND DISTRICT HOSPITAL
L'HÔPITAL DE TIMMINS ET DU DISTRICT

Demographic Label

Secondary Stroke Prevention Clinic Referral Form

The following information **MUST** be completed (incomplete forms will be returned for completion):
Fax completed form and attachments to **(705) 360-6097**

Patient _____ Best Phone Number to Reach Patient _____

Referring Physician _____ Family Physician _____

Referring Physician Signature _____ OHIP Billing No. _____

Date of Event _____ Reason for Referral _____

Tests Completed or Pending

CT	☐ Complete	
CTA (should be completed within 24 hours of presentation)	☐ Complete	☐ Pending
MRI/MRA	☐ Complete	☐ Pending
Carotid U/S	☐ Complete	☐ Pending
ECG	☐ Complete	☐ Pending
Relevant Bloodwork (including HbA1c and lipid profile)	☐ Complete	☐ Pending
Echo	☐ Complete	☐ Pending
Holter Monitor (consider m-Health Solutions)	☐ Complete	☐ Pending

- Referral Sent To: _____

Clinical Features

☐ **Unilateral Weakness**	☐ Face	☐ Arm ☐ Leg	☐ Right ☐ Left
☐ **Unilateral Sensory Symptoms** (must affect two contiguous segments)	☐ Face	☐ Arm ☐ Leg	☐ Right ☐ Left
☐ **Speech Disturbances**			
☐ **Visual Loss**	☐ Right	☐ Left	
☐ **Other:**			

☐ **Duration of Symptoms:**
- ☐ Less than 10 minutes
- ☐ 10–59 minutes
- ☐ 60 minutes or more

Risk Factors

- ☐ Hypertension
- ☐ History of Atrial Fibrillation
- ☐ Diabetes
- ☐ Hyperlipidemia
- ☐ History of Sleep Apnea
- ☐ Ischemic Heart Disease; previous CABG year: _____
- ☐ Previous Stroke or TIA; Date: _____
- ☐ Previous Known Carotid Disease: ☐ L ☐ R _____% stenosis
- ☐ Current Smoker / ☐ Ex-Smoker

Treatment Initiated

☐ Antiplatelet Therapy _____	☐ Started	☐ Continued
☐ Anticoagulant _____	☐ Started	☐ Continued
☐ ACE or ARB _____	☐ Started	☐ Continued
☐ Statin _____	☐ Started	☐ Continued
☐ Other _____		